Homeless in Montana:

a report

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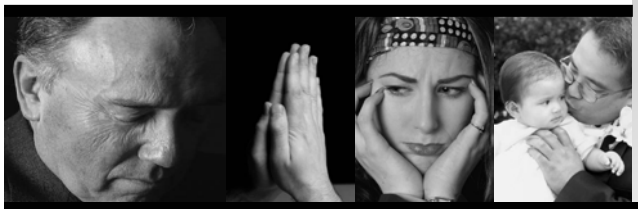
Homeless in Montana:
an Executive Summary



Homeless: *lacking a fixed, regular, and adequate night-time residence... has primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) an institution that provides a temporary residence for individuals or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.*

...adults...children...families...men...women...young...old…White...Native American...

Who am I?

I'm a middle-aged man and I've been your neighbor for more than two years. I graduated from high school, but I've been on your streets for more than a year. I spent last night in a shelter.

Who am I?

I am your neighbor and I need your help.

Who am I?

I am a young woman with a high school education. I have been your neighbor for at least 2 years. I have a child and nowhere to go — we slept on a friend's couch last night. There's a good chance I'm homeless because of domestic abuse and I've been without a home for more than six months.

Who am I?

I am your neighbor and I need your help.

The Survey: An annual point-in-time *Survey of Montana's Homeless* is sponsored by the Intergovernmental Human Services Bureau of the Department of Public Health and Human Services. Efforts were made to reach as many homeless people as possible in seven population centers during the last three days of April. There was no duplication among those surveyed. The survey cannot be considered scientifically valid, but it does provide a good collective look at what it means to be homeless in Montana.

The Demographics

Survey respondents were considered either "individuals" or "families," which was defined as being alone or with family. Included were:

- 516 families with an identified 1,426 members, for an **average family size of 2.76**.
- 1,397 homeless individuals.
- 61% were male, but more women than men were the heads of homeless families.
- Approximately 30% of individuals and 35% of families had *not* achieved a high school education.
- Native Americans were represented at rates 2.2 — 3.6 times expectations established by 2000 Census data.
- 21% of individuals and 27% of families worked either part or full time. A small minority (less than 5%) ask strangers for money.
- Approximately 60% had lived in the area for *at least two years*. More than 20% had been there for at least 6 years.
- 18% of individuals and 20% of families had been in the community for 3 months or less.
- Virtually all families surveyed were likely to be eligible for food stamps, but just 21.7% had them and just 11.4% of individuals had accessed them.
- Disability rates are typically high among the homeless, but just 15.5 percent of individuals and 11.2 percent of families had Supplemental Security Income.

15 factors that commonly precipitate homelessness were listed in the survey. Respondents were told to choose as many as applied. The factors can be grouped into categories:

- Poverty-related issues (e.g., moving costs, eviction, car trouble, lost job/no skills).
- Disability (e.g., mental health and/or substance abuse disorders, physical disabilities, HIV/AIDS),
- Domestic abuse,
- Loss of system support (e.g., released from confinement, aging out of foster care, completing mental health or substance abuse treatment),
- Lifestyle choice.

Individual responses most frequently cited the factors included in the disability category; families most often cited poverty-related factors as having contributed to their homelessness.

Interviewers identified 2,823 homeless Montanans during the point-in-time *Survey of the Homeless* in April 2003.

Obstacles

Implications for Policy

Three factors influence homelessness. The first is structural — the interrelation of housing cost, availability and income. The second is personal vulnerability, which might include mental health, substance abuse, cognitive or physical ability. The third is social policy, which can either ameliorate or worsen the other factors.

— Martha Burt, Director of the Social Service Research Program of the Urban Institute

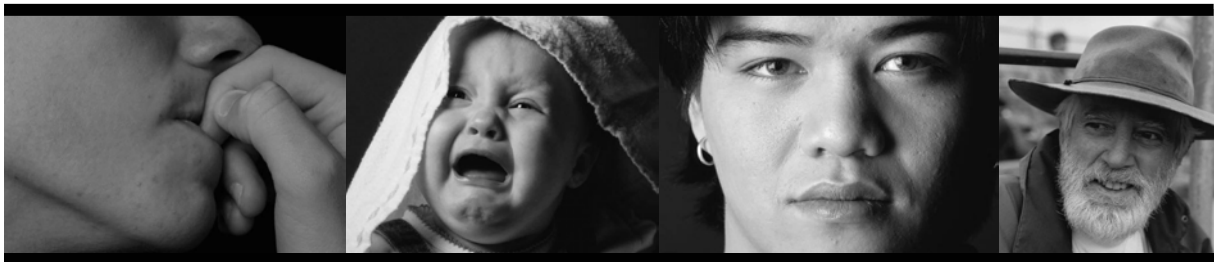
- **Lack of low-come housing:** In December 2003, 7,500 families were on the Department of Commerce waiting list for housing assistance vouchers, and the wait can vary from 18 months to 7 years.
- The lack of housing is only one of the **obstacles to becoming housed**. Lack of references, poor credit, criminal records and large rental deposits are all barriers to becoming housed. The #1 response to "What do you need?" by family *and* individual respondents was "help finding a place to live."
- **Access to mainstream services:** While virtually all families surveyed may have been eligible for mainstream assistance, less than one in four had accessed Temporary Assistance for Needy Families (TANF).
- **Poverty** is widespread in Montana, with the majority of employment opportunities paying less than the living wage required to access housing at the Fair Market Rent.
- **Gender-based wage inequality** is extreme, putting women without partners at high risk of homelessness as the direct result of poverty-related issues.
- **Substance abuse, mental illness and co-occurring disorders** are prevalent, but for many, in-patient treatment is difficult to access or involves a waiting list.
- **Education**: About 1/3 did not have the equivalent of a high school education and around 40% stated that they needed job training, skills or counseling.
- **Lack of consistent policies** can mean discharge planning is incomplete or inadequate. Loss of system support — whether mental health or chemical dependency treatment, foster care or corrections — can put people at high risk of homelessness.

In 2003, 11 Montana stakeholders attended the 4th National Policy Academy on Chronic Homelessness, designed to help policymakers improve access to mainstream services for people who are homeless. The group established the following priorities and created a work plan to use as a starting point for addressing the multi-faceted problem of homelessness in Montana.

Priority #1: Coordinated Services
Priority #2: Case Management
Priority #3: Mobilize Resources
Priority #4: Outreach

- Form an active **Council on Homelessness** to create a collaborative *10-Year Plan* designed to end chronic homelessness within ten years.
- Determine and implement ways to **supplement affordable housing stock** and examine ways in which we can remove some of the programmatic obstacles to becoming housed.
- Look at the ways to affect **root causes** of homelessness through policy. These might include poverty, treatment availability for substance abuse/ mental illness, domestic abuse, lack of training or education, and inadequate discharge policies resulting in the abrupt loss of system support.
- **Partner with the Tribal Nations** to develop understanding of homelessness on the reservations and to find culturally competent solutions to homelessness.
- Enhance **collaboration** to increase access to mainstream resources for hard-to-serve homeless populations, including homeless veterans.
- **Inventory** a range of program discharge policies and practices and use that as a base to help initiate consistent practices geared to preventing homelessness and creating effective transitions.
- Perhaps the most compelling fact revealed by these data is the **multiplicity of needs** and the variety of local, state, and federal programs and agencies that are required in order to address the needs. Coordinated multi-agency strategies are needed to effectively combat homelessness.

HOMELESS IN MONTANA



...adults...children...families...men...women...young...old…White...Native American...

Homeless: *lacking a fixed, regular, and adequate night-time residence... has primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) an institution that provides a temporary residence for individuals or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.*

Survey Highlights

The annual point-in-time Survey of Montana's Homeless sponsored by the Intergovernmental Human Services Bureau of the Department of Public Health and Human Services (DPHHS) was administered statewide April 28 — 30, 2003. Volunteers and non-profit workers in each of seven major population centers reached as many of Montana's homeless people as possible during that time. There was no duplication among those surveyed.

The questions and survey dates were consistent statewide, but the survey cannot be considered definitive or scientifically valid because methodology was left to the discretion of the agencies administering it. Those who conducted it on the streets elicited different snapshots of the homeless than those working through the homeless shelters. Even so, the composite results provide a valuable snapshot of what it means to be homeless in Montana.

The Data

Respondents were considered either "individuals" or "families," which was defined as being alone or with family. There were 516 families with 1,426 members, for an average family size of 2.76 people. There were also 1,397 homeless individuals surveyed. All told, 2,823 homeless people were identified.

Age: Among identified families and individuals:

- 19%: were under age 14
- 8%: 14—17
- 7%: 18—21
- 20%: 22—34
- 20%: 35 — 44
- 22%: 45 — 60
- 4%: 61 — 72
- 1%: Aged 72+

Gender: Overall, 61 percent of the those surveyed were male, though more women than men were the heads of homeless families.

Ethnicity: Minority representation was extremely disproportionate, with Native Americans represented at rates 2.2 — 3.6 times higher than would be expected on the basis of 2000 Census data.

Educational Attainment: The majority — 70.1 percent of individuals and 64.9 percent of family representatives — had either a GED, diploma or degree.

Tenure in the Community: Most of the homeless people surveyed were *not* strangers to the community. Approximately 60 percent of the homeless people surveyed had lived in the area for at least two years. More than one in five had been there for a minimum of six years. Eighteen (18) percent of individuals and 20 percent of families had been there for 3 months or less.

Interviewers identified 2,823 homeless Montanans during the point-in-time *Survey of the Homeless* in April 2003.

Influences on Homelessness

Time Homeless: Nearly one-third (32.9 percent) of the homeless individuals interviewed and 22.3 percent of those representing families had been homeless for more than a year.

Where did you sleep last night? The top two options were staying with friends or relatives and emergency shelters. Comparatively few reported coming from detoxification facilities, hospitals or correctional facilities.

Contributing Factors: Respondents were given a choice of 15 factors and asked to choose all that applied. There were marked differences in the responses of the two groups. The top 5 responses for each group were:

- **Families**

1. Lost job/no skills: 24.2%
2. Moving costs: 22.3%
3. Domestic abuse: 21.5%
4. Mental health: 18%
5. Evicted: 17.4%

- **Individuals**

1. Mental health: 33.7%
2. Drugs/alcohol: 27.2%
3. Lost job: 21.9%
4. Lifestyle choice: 20.4%
5. Moving costs: 6.3%

***Note:** 5.6% of families and 12.7% of individuals cited co-occurring mental health and substance abuse disorders as factors contributing to their homelessness.*

2003 HHS Poverty Guidelines	
Family Size	**2003**
1	$ 8,980
2	12,120
3	15,260
4	18,400
5	21,540
6	24,680
7	27,820
8	30,960
For each additional person, add	3,140

Homeless families included 272 children age 0 — 6

POVERTY

According to the Department of Commerce *Economic and Demographic Analysis of Montana* (2003):

- Montana's poverty rate has decreased since 1990, but the number of families in poverty actually increased by 20.7%.
- The unemployment rate has dropped by 1/3 over the past decade, but new jobs are in low-paying sectors.
- 41.6% of female householders with children under age 18 and no husband present live in poverty.
- *More than half* (58.5%) with related children under age 5 live in poverty. (2000 Census)

Income Inequality

Income inequality in Montana has grown until by the late 1990s, the income of the wealthiest 20% of families was 9.3 *times* that of the poorest 20%. In comparison, during the late 1980s, the wealthiest 20% of families had 7.2 times the income of the poorest 20% of families.

Wage Inequity by the Numbers

2000 Census data revealed that 84% of Montana women wage earners make less than $30,000 a year, compared to 63% of working men. This table shows a comparison of annual earnings.

Earnings per Year (2000)	Montana Population Age 16+	
	Men	**Women**
Less than $20,000	44%	68%
$20,000 – 29,999	19%	16%
$30,000 – 49,999	23%	12%
$50,000 – 99,999	11%	2%
$100,000 or more	3%	2%

Source: *Montana Women's Report December 2002.* (wordinc.org/cpacc/mtwomenecon 1202.pdf)

2000 Census data reveals that females working full-time, year-round had median earnings equating to just 69 percent of that of their male counterparts. Full-time, female workers in Montana earned a median wage of $20,914, as compared to the $30,504 earned by males.

- According to the *Montana Women's Report* (Kindrick: 2002), nearly 60% of Montana women earn less than a living wage, or a wage that allows a family to meet basic needs without public assistance, and which provides for some ability to deal with emergencies and to plan ahead.
- For a single adult, a living wage is $20,500 a year. In 1998 the majority of jobs with the fastest rate of growth in Montana's economy paid less than $20,000 a year. (*National Priorities Project*)

Influences on Homelessness

Lack of Low Income Housing

What do you need?	Individuals	Families
1. Help finding a place to live	57.4%	57.9%
These values are based on the number of respondents stating they need help with this.		

A January 2004 interview with George Warn, Montana's Housing Assistance Bureau Chief, revealed that 4,000 low-income housing units are assisted through the Montana Department of Commerce (MDOC). There are also:

- 4,355 project-based Section 8 units, and
- 4,000 units through 12 public housing authorities in Montana.

Project based units are owned by unaffiliated investors, so there are no composite waiting lists for these units. Each of the state's 12 public housing authorities maintains its own waiting list as well. There can be significant duplication among lists.

The lack of low income housing is only one of the obstacles to becoming housed. Lack of references, poor credit, criminal records — especially violent or drug-related offences — and rental deposits consistent with community standards all serve as barriers to becoming housed.

In December 2003, 7,500 families were on the MDOC waiting list for housing vouchers. Families are chosen for participation in the MDOC units from the wait list on a first-come, first-served basis. The wait varies from 18 months to 7 years. At any point in time, approximately 600 Montanans hold housing vouchers and are actively seeking housing. They have a maximum of 120 days to secure housing. If unsuccessful, the voucher reverts to the next eligible person on the list.

To be considered *affordable*, housing costs including rent and utilities cannot exceed 30 percent of income; 2000 Census data reveals that 28.2 percent of *all* Montana renters pay 35 percent *or more.*

- According to the *2001 State of Growth in Montana,* 47 percent of Montana renters cannot afford fair market value for a 2-bedroom unit ($537/month). (mtsmartgrowth.org)

According to the National Low Income Housing Council (www.nlihc.org), a full-time worker earning minimum wage must work 80 hours per week to afford a 2-bedroom unit at Fair Market Rent.

- A minimum wage earner (earning $5.15 per hour) can afford monthly rent of no more than $268/month.
- In Montana, an extremely low income household (30 percent of the Area Median Income of $44,151) can afford monthly rent of no more than $331; Fair Market Rent for a 2-bedroom unit is $537.
- A Supplemental Security Income (SSI) recipient whose only income is the $552 monthly stipend can afford monthly rent of no more than $166. Fair Market Rent for a 1-bedroom unit is $405.
- A Montana worker earning the "housing wage" of $10.32/hour would gross $21,465.60/year; 26 percent of Montana households earn less than $14,999 annually. (Census 2000)

Tina's trailer is tiny and the windows are covered with plastic for warmth: there's no insulation in the 2" walls. The floor is plywood - she pulled up the linoleum trying to get rid of the smell of urine. She's on the housing authority waiting list, but is currently paying $335/month in rent. Her electricity is $30 a month; another $100 a month goes for propane. Tina is a full-time student receiving public assistance. Before her baby came, she received $114 in food stamps and $97 from FAIM each month. LIEAP provided some help during the cold months, but there isn't an extra dime.

— The Many Faces of Poverty (2001)

CHRONIC HOMELESSNESS

Chronic homelessness is defined as, "An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or has had at least four (4) episodes of homelessness in the past three (3) years." (HUD, HHS and VA)

According to *Ending Chronic Homelessness: Strategies for Action* by the US Department of Health and Human Services (2003), longitudinal analyses of homeless service users create distinctions among homeless persons. The group is *not* homogeneous, but comprised of three subgroups.

1. ***Temporarily homeless*** — persons who experience only one spell of homelessness (usually short) and who are not seen again by the homeless assistance system;
2. ***Episodically homeless*** — those who use the system with intermittent frequency, but usually for short periods; and
3. ***Chronically homeless*** — those with a protracted homeless experience, often a year or longer, or whose spells in the homeless assistance system are both frequent and long[1].

2003 Survey of the Homeless

- 444 (33 percent) of individuals and 109 (22.3 percent) families had been homeless for longer than a year.
- 51 percent of individuals and 46 percent of families had been without safe, permanent housing for more than six months.
- Per the table below, significant numbers cite one or more disabling conditions as factors in their homelessness.

	Individuals		Families	
	#	%	#	%
Drugs/Alcohol	380	27.2%	86	16.7%
Mental Health	471	33.7%	93	18.0%
Co-occurring Mental Health and Substance Abuse Disorders	177	12.7%	29	5.6%
HIV/AIDS	5	0.4%	1	0.2%
Physical Disability	185	13.2%	48	9.3%

This is consistent with federal Homeless Policy Academy materials, which indicate that 80 percent of those who experience homelessness each year exit within 3 — 4 weeks, 10 percent are episodically homeless, and 10 percent experience chronic homelessness.

The chronically homeless as a group face numerous barriers. They exhibit high levels of disability, aren't engaged with conventional community life, have multiple service needs and yet still must navigate largely fragmented systems. (*Ending Chronic Homelessness, 2003.*)

Montana's 2003 Survey of the Homeless

Time Homeless	Individuals		Families	
Less than 1 month	(157)	11.6%	(62)	12.7%
More than 1 month	(186)	13.8%	(82)	16.8%
More than 3 months	(218)	16.2%	(103)	21.1%
More than 6 months	(247)	18.3%	(116)	23.8%
More than 1 year	(444)	32.9%	(109)	22.3%
Unsure	(96)	7.1%	(16)	3.3%

"I move by Greyhound and have lived in four places in four years." Camelot ticks them off on her fingers, "Idaho, Washington, South Carolina, Montana. Thanks to the housing authority, we have a house now. We were homeless before this." - *The Many Faces of Poverty (2001)*

The "typical" homeless individual represented in the 2003 Survey was a white male between the ages of 45 - 60. He's been on the streets for more than a year, and spent the previous night in a shelter. He finished high school and has lived in town for at least two years.

The "typical" homeless head of a family was a white female between the ages of 22 - 34. She has a high school education, a child and a one in five chance of having become homeless because of domestic abuse. She's been homeless for more than 6 months; she and her child spent the previous night with friends or family.

Sources Cited

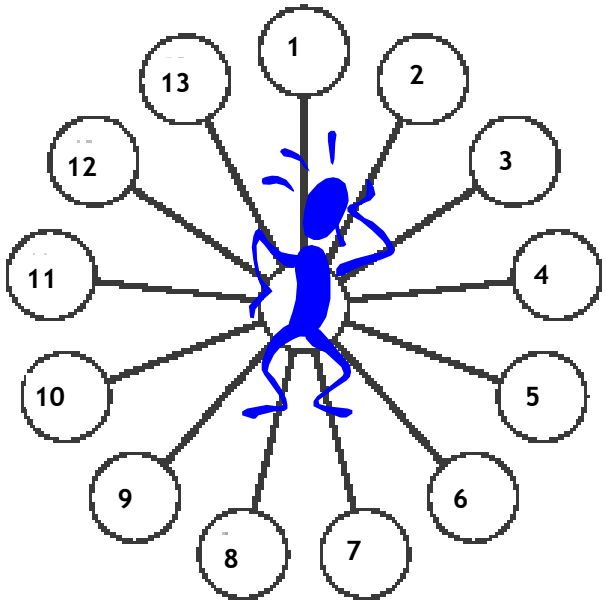
1. Ending Chronic Homelessness: aspe.hhs.gov/hsp/homelessness/strategies03/ch.htm#ch2
2. Homeless Policy Academy: http://www.hrsa.gov/homeless/pa_materials

MULTIPLE SERVICE NEEDS

The needs of a chronically homeless person to cross many service system boundaries, beginning with the most basic human needs.

1. Emergency shelter
2. Food
3. Transitional/permanent housing
4. Substance abuse treatment
5. Primary health care treatment
6. Mental health treatment
7. Case management/brokering services
8. Cash assistance
9. Entitlements and income supports
10. Life skills
11. Community living skills
12. Family reunification
13. Job skills/self-sufficiency

(Text and figure adapted from Ending Chronic Homelessness: Strategies for Action, US Department of Health and Human Services. 2003.)



The array of service needs associated with chronic homelessness

What the homeless in Montana say they need...

The 2003 Survey asked, "*Do you or anyone in your family need any of the following?*" Respondents were encouraged to select as many of 15 different items as were applicable. There were 5,220 positive "hits" from individuals and 1,979 from families, indicating an array of needs for each respondent. Per the table at right, the top 3 ranking items were the same for both groups.

The needs can be broken down into broad categories, including 1. basic needs (food, shelter and/or clothing); 2. health needs (medical, prenatal, substance abuse and/or mental health treatment); 3. skills/training or education; and 4. access to mainstream services (childcare, transportation, Veterans' and/or legal assistance). Overwhelmingly, the category receiving the most positive responses was the basic needs category — 41% of *all* individual responses and 36% of all family responses fell there. Perhaps the most compelling fact revealed is the multiplicity of needs and variety of local, state and federal programs required to address those needs. Coordinated multi-agency strategies will be key to combatting homelessness in Montana.

What Do You Need?	Individuals	Families
1. Help finding a place to live	*57.4%*	*57.9%*
2. Food or clothing	**51.0%**	**47.1%**
3. Medical care	**45.8%**	**47.1%**
A regular place to sleep	45.2%	31.4%
Job training, skills or counseling	39.9%	42.1%
Mental health care or medication	38.9%	31.8%
Drug/alcohol treatment	27.4%	20.7%
Child care	1.5%	26.2%
School	14.9%	22.5%
Transportation to work	17.0%	19.0%
Legal assistance	16.5%	18.4%
Transportation to relocate	6.0%	7.2%
Prenatal care	0.6%	4.8%
Veterans' assistance	5.0%	3.7%
Other	6.5%	3.7%

These values are based on the ***number of respondents*** stating that they needed help in these areas.

Hometown Homelessness

Montana's homeless are not strangers. Approximately 60 percent of individuals and families responding to the 2003 Survey had lived in the area where they were homeless for *two years or more*.

How long have you lived in this community or area?

Eighteen (18) percent of homeless families and 20 percent of homeless individuals had been in the area for *3 months or less,* but the majority of those surveyed had ties — at least of longevity — to their locales. For the most part, they were *not* strangers to our communities and yet even among those with significant community tenure, intra-area mobility and residential instability are high.

National Center on Family Homelessness data reveals that homeless families have moved nearly 4 times in the past 2 years, as compared to their housed counterparts, who moved almost twice in the same period. (familyhomelessness.com)

- 21.3 percent of Montanans moved into their current dwellings within the last year; an additional 27.5 percent within the past 4 years. (2000 Census)

Kids and Mobility

- Approximately 10% of Montana's 8th, 10th and 12th graders have moved *7 or more times* since kindergarten.
- On average, 20 percent have changed homes in the past year.
- 19 percent have changed schools 5 or more times since kindergarten.

Source: 2002 Prevention Needs Assessment Data oraweb.hhs.state.mt.us:9999/images /prev/ download/ surveys_02/mtrp2002.pdf

Hometown homelessness is not unique to Montana. Homelessness became such a ubiquitous problem in the United Kingdom that they created a solution designed for application at the *local level*. Housing is provided for those deemed eligible by virtue of priority need, unintentional homelessness and "*local connection*" to the area.

www.shelternet.org.uk/homeless/connection-539-Een-f0.cfm

Time in Community	Individuals	Families
Less than a month	(148) 11.0%	(29) 5.9%
1-3 months	(120) 8.9%	(58) 11.8%
4 months - 1 year	(295) 21.9%	(110) 22.4%
2 -5 years	(291) 21.7%	(114) 23.3%
6-10 years	(111) 8.3%	(47) 9.6%
11-20 years	(120) 8.9%	(44) 9.0%
21+ years	(88) 6.5%	(19) 3.9%
Entire life	(171) 12.7%	(69) 14.1%

2003 Survey of the Homeless in Montana

Resources and the Local Connection

More than half — 55.3% of individuals and 76% of the families surveyed had income — and 21% of individuals and 27.1% of families were working either part or full time. A very, very small minority stated that they resorted to asking strangers for money.

2003 Survey Responses	Individuals	Families
Had some income	55.3%	76.0%
SSI	15.5%	11.2%
Part-time job	14.3%	12.8%
Food stamps	11.4%	21.7%
Other	6.9%	7.2%
Full-time job	6.7%	14.3%
Social Security	6.0%	4.1%
Selling personal belongings	4.9%	5.4%
Asking strangers for money	4.7%	1.6%
Family/friends	3.0%	8.7%
Veterans benefits	2.7%	1.0%
TANF or FAIM	1.1%	23.3%
Savings	1.1%	0.4%

Where did you *sleep* last night?

In one study, among *housed l*ow-income families, 55 percent spend more than 30 percent of their income on housing and 49 percent have doubled-up with family or friends in the past two years. www.familyhomelessness.org/

The table below reflects an aggregate picture of how Montana's homeless individuals and families are meeting their needs for shelter. Often that means turning to friends or relatives. One study — *Your Place, Not Mine: a study of homeless people staying with family and friends* — made an effort to uncover the extent and experiences of this kind of "hidden" homelessness. The study revealed that staying with friends or relatives is often the first response of the newly homeless. At that point, many have limited awareness of their options coupled with immediate need and an overwhelming sense of shame. According to the study, staying with friends is a short-term fix at best, with stays lasting no more than a couple of weeks. (www.crisis.org.uk/pdf/YourPlaceSummary.pdf)

Where did you stay last night?	Individuals	Families
1. Emergency shelter	30.5%	22.4%
2. Friends/relatives	19.3%	32.9%
3. On the streets	14.3%	3.4%
4. Own home/apartment	14.3%	17.8%
5. Camp/tent/motor home	6.2%	6.0%
6. Jail, prison or prerelease	5.4%	0.6%
7. Hotel/motel	5.1%	14.0%
8. Car	3.2%	2.0%
9. Hospital	1.1%	0.2%
10. Detox facility	0.6%	0.6%

"I work at Hardees, but I'm thinking of quitting and going to Target. I'm a supervisor at Hardees, but I don't make $6.25 an hour yet – that's how much I'll get raised to in 3 months."

— The Many Faces of Poverty (Rocky Mountain Development Council: 2001)

If you stayed in your own home last night, why are you homeless now?

The survey asked the 195 individuals and 89 families who reported staying in their own homes or apartments the night before why they were homeless now. The majority (71.4 percent of individuals and 63.8 percent of families) answered that they were either living in transitional or permanent supportive housing, and a significant number of families (17.4 percent) said they'd been evicted.

What is transitional housing?

According to the Department of Housing and Urban Development (HUD), transitional housing is a project that has as its purpose facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months).

THE 3-FACTOR THEORY

There are three factors influencing homelessness. The first is structural — the interrelation of housing cost, availability and income. The second is personal vulnerability, which might include mental health, substance abuse, cognitive or physical ability. The third is social policy, which can either ameliorate or worsen the other factors.

— Martha Burt, Director of the Social Service Research Program of the Urban Institute

It includes housing primarily designed to serve deinstitutionalized homeless individuals and other homeless individuals with mental or physical disabilities and homeless families with children. The criteria for transitional housing include:

1. 6—24 month residence;
2. distinct units;
3. accessed through referral;
4. commitment by the resident to engage in supportive services; and
5. residents set goals for becoming stable community members.

Some examples include shelters for victims of domestic abuse, halfway houses, group homes and the Addictive and Mental Disorder Division's recovery and mothers' and children's homes.

Special Needs Populations: *Kids and Moms*

Homeless Kids

The National Mental Health Association states that families are the fastest growing segment of the homeless population, accounting for almost 40 percent of the nation's homeless. The numbers captured in Montana were even higher. The 2003 *Survey of the Homeless* identified 1,426 individual family members. This number included 577 children under the age of 18.

- 144 families had one child between the ages of 0–6;
- 52 families had two children under age 6.
- 40 women were pregnant.

According to the *Education Commission of the States* (www.ecs.org), homeless children face hardships that include frequent mobility, poor nutrition, substandard living conditions, emotional stress and lack of access to health care. Parents engaged in a daily struggle to secure shelter for the night may have difficulty meeting even such basic needs as school supplies and appropriate clothing. These factors often result in multiple problems in the education setting and predispose children to school drop-out, risk behaviors including drug and alcohol use, teen pregnancy and engagement in the juvenile justice system.

The Office of Public Instruction (OPI) sponsors Montana's Homeless Education Program. The purpose is to ensure that "each child of a homeless individual and each homeless youth has equal access to the same free, appropriate public education, including a public preschool education, as provided to other children and youths."

The last time the Montana Homeless Education Program was required to count homeless children and youth in Montana's schools was 1998. The Montana OPI also did actual counts in 1988 and 1990. Since then the program has done statistical sampling to estimate the number of homeless children. Sampling was done in 1992, 1994 and 1998. The number of homeless kids in Montana increased each year, as it did nationally.

Montana OPI Count of Homeless Children and Youth*

Primary nighttime residence	Number of children
Shelters	1,132
Doubled up	1,046
Other	140
Total	2,459
In addition to the numbers above, there are 368 preschool children.	

*As reported to Congress in 1999. www.opi.state.mt.us/

...and Moms

Housing and difficulty competing in school are far from the only issues homeless children and youth are dealing with. The National Center on Family Homelessness is performing comprehensive research on sheltered homeless and low-income housed families and their children. The study has yielded some disturbing findings about homeless mothers and their housed, low-income counterparts.

- More than 40 percent of homeless and housed low-income mothers included in the study had experienced a major depressive disorder.
- More than 1/3 had experienced Post Traumatic Stress Disorder (three times the rate of the general female population).
- 31 percent of homeless mothers and 26 percent of housed low-income mothers have attempted suicide at least once, usually in adolescence.
- More than 40 percent of homeless and housed low-income mothers were sexually molested as children, and by age 12, 60 percent had been severely physically or sexually abused.
- Homeless and housed low-income mothers are in poor health. Nearly 1/3 report a current chronic health condition, with particularly high rates of asthma, anemia and ulcers, despite the fact that their average age was 27.

Source: National Center on Family Homelessness. familyhomelessness.org/research_ evaluation/research.html

Domestic Abuse: Partner and family member abuse comprised at least 22.5 percent of *all* aggravated assaults and 21.7 percent of all rapes in Montana in 2001. (Montana Board of Crime Control)

- 2001 marked the highest partner and family member abuse offense rate in a 13-year period, with 649.8 offenses per 100,000. Between 2000 and 2001, there was an 11.3 percent increase in the simple partner and family member abuse rate.
- In 2001 alone, there were 3 homicides, 88 rapes, 348 aggravated assaults and 3,716 simple assaults tied to partner and family member abuse.

Special Needs Populations: *Disability*

DISABILITY: ***"... a physical or mental impairment that substantially limits one or more of the major life activities."*** — Americans with Disabilities Act of 1990

Poor health is a cause and a consequence of homelessness.

- Without health insurance, the onset of an illness or disability can easily result in homelessness.
- Homeless people experience a high prevalence of infectious diseases, mental illness, and co-occurring addiction and substance abuse disorders.
- While homeless, it can be difficult to make and keep medical appointments.
- People experiencing homelessness often have no place to rest and recuperate, or to store medications.

Constant moving, especially from shelter to shelter, affects the health and well-being of each family member. National data indicates that nearly one-third of homeless people have a chronic health condition*.

In response to the Montana Survey:

- Nearly half of the individuals (45.8%) and families (47.2%) surveyed needed medical care.
- According to the National Coalition for the Homeless, approximately 20-25 percent of single adult homeless population suffers from some form of severe and persistent mental illness. This is relatively consistent with the Montana survey results, as is demonstrated by the table below.

Homelessness inevitably causes serious health problems. Illnesses that are closely associated with poverty - tuberculosis, AIDS, malnutrition, severe dental problems - devastate the homeless population. Health problems that exist quietly at other income levels - alcoholism, mental illnesses, diabetes, hypertension, physical disabilities - are prominent on the streets. Human beings without shelter fall prey to parasites, frostbite, infections and violence.
- National Health Care for the Homeless Council

2003 Survey Results	Individuals		Families	
Disability	#	%	#	%
Drugs/Alcohol	380	27.2%	86	16.7%
Mental Health	471	33.7%	93	18.0%
Co-occurring Mental Health & Substance Abuse	177	12.7%	29	5.6%
Physical Disability	185	13.2%	48	9.3%
HIV/AIDS	5	0.4%	1	0.2%

Disability Status of Montana's Civilian Noninstitutionalized Population	
Population 5 –20 years with a disability	7.1%
Population 21–64 years with a disability	16.9%
Population 65+ years with a disability	39.6%

2000 Census data

The disability status of the general population listed above includes an aggregate number for all types of disability — physical, developmental, mental and others. The disability rates among the homeless Montanans surveyed reflect much higher disability rates (see table below). Disability in and of itself can be a risk factor for homelessness. Poverty coupled with disability gravely enhances the risk of homelessness.

Supplemental Security Income (SSI) is a federal program designed to help aged, blind and disabled people who have little or no income by providing cash to meet basic needs for food, clothing and shelter.

- Among those responding to the 2003 Survey, 206 (15.5%) of individuals and 58 (11.2%) of families received SSI benefits.
- The maximum monthly federal SSI payment for an individual living in his or her own household and with no other countable income is $564; for a couple it is $846. (January 2004). Fair Market Rent for a 1-bedroom unit in Montana is $405, or 72% of the individual stipend.

*Denver Business Journal: http://www.bizjournals.com/denver/stories/1997/11/17/editorial4.html)

Mental Illness and Additive Disorders

Mental Health: Montana's mental health services budget has been in crisis for several years, in response to budgetary shortfalls and a sharply increased demand for services.

- The number of respondents reporting that mental health and/or substance abuse issues had contributed to their homelessness on the 2003 Survey of the Homeless was overwhelming. Out of a universe of 516 families and 1,397 individuals:
  - 27.2% of individuals and 16.7% of families cited drug/alcohol issues;
  - 33.7% of Individuals and 18% of families cited mental health issues; and
  - 12.7% of individuals and 5.6% of families cited co-occurring disorders.
- Montana State Hospital (MSH) is the only publicly funded in-patient psychiatric hospital in Montana. It is licensed for 174 beds, with 15 additional group home beds geared to transitioning patients to the community.
- The number of admissions to the State Hospital has jumped by 35 percent since 1993; the hospital exceeded its capacity of 189 many times during FY 2003.
- The most common diagnoses among MSH patients included schizophrenia and psychotic delusional (49%) and affective disorders (25%). Left untreated, these disorders make it impossible to function well enough to hold a job, seek benefits — or secure and maintain housing.
- On an out-patient basis, the Mental Health Bureau of the Addictive and Mental Disorders Division (AMDD) provided community-based mental health services to 24,600 Montanans of all ages in FY 2003. This is down about 5 percent, from 25,889 in FY 2002.
- Montana's data appears to be consistent with National Mental Health Association fact sheets state that about 1/3 of the Americans who are homeless on any given night have serious mental illnesses and that more than 1/2 also have substance use disorders. (www.nmha.org)

"Many of the patients at Montana State Hospital either don't have homes to begin with or lose their residences when they enter the hospital. Although there isn't a waiting list to get in, there are often waiting lists for community-based mental health services. This can result in prolonged hospitalization, particularly among those who are either homeless or at high risk for homelessness."
— Ed Amberg, Administrator

Throughout Montana, methamphetamine use has been linked to a wide range of other crimes, from partner assaults and forgeries to robberies, internet crime and drive-by shootings.

Substance Abuse: Montana Chemical Dependency Center (MCDC) is Montana's *only* publicly funded in-patient treatment facility. It typically has a waiting list that is several weeks long.

- On average, 16 - 20 people are admitted to MCDC weekly. (AMDD Annual Report: '03)
- Based on the AMDD *1997 Adult* Household *Telephone Survey and FY 2001 service data,* approximately 88% of the 53,107 Montana adults in need of treatment in 2001 did not receive it.
- 95% of the estimated 14,693 youths needing treatment did not receive it.
- A 2001 study of substance abuse needs on Montana's reservations tied poverty to substance abuse rates. Some of the highest poverty levels in the nation can be found on Montana's reservations. Drug abuse rates are also substantially higher than they are in non-reservation areas.
- AMDD has come to view co-occurring mental illness and substance abuse disorders as the expectation rather than the exception among their clients.
- Methamphetamine use, production and distribution appears to be growing throughout Montana, as evidenced by the jump from the 16 meth labs discovered in 1999 to the 122 labs in 2002. This drug is nearly immediately addictive and current studies reveal lasting damage to cognitive functioning.

On the 2003 Survey of the Homeless, 27.4 percent of individuals and 20.7 percent of families reported needing drug/alcohol treatment; 38.9 percent of individuals and 31.8 percent of families reported needing mental health treatment and/or medication.

Special Needs Populations: Veterans

Veterans: Montana's 2003 Survey revealed lower numbers of veterans among the homeless persons surveyed than national Department of Veterans Affairs (VA) estimates would indicate. National VA data indicates that nearly 25 percent of homeless adults are veterans, but 17.8 percent (248 individuals) identified themselves as veterans.

- 65 of them were carrying a VA enrollment card or their discharge papers with them.
- 53% had served in Vietnam, Korea or World War II.
  - 122 were in Vietnam between 1961—1975;
  - 9 were in Korea between 1950—1955;
  - 1 was in World War II.

In 2002, the VA spent nearly $216 million in Montana to serve approximately 108,000 veterans. In 2003, 24,190 people received health care in Montana's VA facilities and 14,726 Montana veterans and survivors collected disability compensation or pension payments. ww1.va.gov/opa/fact/statesum/docs/mtss.htm

Among those surveyed, just 38 (2.7%) of homeless individuals and 5 (1%) of homeless families surveyed were receiving VA benefits. Even so, just 70 (5%) of the homeless individuals and 19 (3.7%) of the homeless families surveyed stated they needed help accessing VA benefits.

16.2 percent (108,476) of Montana's population was comprised of veterans at the time of the 2000 Census.

The Department of Veterans' Affairs

The VA is the only federal agency providing substantial hands-on assistance to the homeless. It has the largest network of homeless assistance programs in the country. VA provides outreach, conducts clinical assessments, offers medical treatment and provides long-term shelters and job training.

Homeless veterans in Montana receive outreach services including primary health care, mental health and substance abuse counseling and case management services at the Fort Harrison medical center outside Helena. Primary care is available to homeless veterans in community outpatient clinics with referrals to the medical center for specialized care. Partnerships with shelters, community-based outpatient clinics and others was established and a referral network developed. Homeless veteran program coordinators from the medical center and the VA Regional Office routinely visit homeless shelters. From this referral network, homeless veteran program coordinators act as access points for homeless veterans seeking services. (www1.va.gov/opa/fact/statesum/docs /mtss. htm)

Risk Factors for Homelessness: According to *Addressing Issues From Hunting to Homelessness: A Report to the 57th Montana Legislature,* about 18,000 unduplicated veterans presented for care in the VA Montana Health Care System during FY 1999, a 17 percent increase from FY 1998. Claims and eligibility determinations are processed through Veterans Benefits Administration (VBA) offices. The initial step in a claim for disability compensation or pension benefits involves evaluating a veteran's disabilities or injuries as well as the extent to which each disability or injury is service-connected. For each determination, a veteran must undergo appropriate medical or psychological examinations. Eligibility criteria are also applied to each case. After all determinations and appeals are complete, a determination is made as to what and how much the veteran is eligible for.

Claim backlog: Nationally, the VBA has a backlog of about 450,000 claims with no progress toward reducing that backlog. It routinely takes 6 –12 months to process a claim. More than 70,000 appeals are initiated annually because of incomplete, erroneous or disputed determinations. Each appeal takes about 2 years to *reach* the Board of Veterans' Appeals. Based on historical data, less than 20 percent of the claims are allowed; between 30 – 50 percent are returned for readjudication because of incomplete documentation or lack of required development. This process typically takes 1 – 2 years *and many cases are sent back two or three times.* leg.state.mt.us/content/publications/committees /interim/1999_2000/state_ administration/finalreportvets.pdf#xm

Homeless veterans struggling with multiple issues are hard pressed to meet multiple demands over extended periods.

Minorities

Disproportionate Minority Representation: Minority people are overrepresented among Montana's homeless population. This is particularly true in relation to Native Americans, who are represented at rates 2.2 — 3.6 times higher than Census data would dictate. The table below compares the percentage of minority people represented in the *2003 Survey of the Homeless* with Montana Census data. This overrepresentation is consistent with what is happening nationally.

Little is known about what homelessness looks like on Montana's reservations, which encompass approximately 13,084 highly rural square miles. Per the table below, American Indian people are represented among the homeless at highly disproportionate rates, in total accounting for 180 individuals and 111 families. Poverty and lack of living wage jobs are pivotal precursors to homelessness among *all* Montanans. These factors are particularly evident among the tribes:

- Poverty on the reservations ranged from a low of 34 percent on the Blackfeet Reservation to 50 percent on the Northern Cheyenne at the time of the 2000 Census;
- Tribal calculations for 1999* revealed extremely high unemployment rates, ranging from 36 — 76 percent of the labor force on the reservations.
- Among those who are employed, 12 — 40 percent had incomes below poverty.

*Northwest Area Foundation indicators: indicators.nwaf.org.

Ethnicity	2003 Survey of the Homeless		2000 Census
	Individuals	Families	Overall
White	78.5%	67.7%	90.6%
African American	2.2%	1.6%	0.3%
Native American	13.5%	22.6%	6.2%
Hispanic	2.5%	3.3%	2.0%
Asian	0.4%	0.8%	0.5%
Multi-racial	2.2%	3.7%	1.7%
Other	0.7%	0.4%	0.6%

Tribal Sovereignty

Federally recognized tribes are dependent sovereign nations with full authority to govern the day-to-day tribal affairs of the members residing on the reservations. While certain federal laws apply on the reservations, state laws are applicable only to the extent of Congressional provision or when the state and the individual tribe concur in its application.

- There are 10 federally recognized Indian Nations located on seven reservations within the boundaries of Montana; another tribe is in the process of gaining federal recognition.

For purposes of federal programs, the tribes on combination reservations (including Fort Peck, Fort Belknap and Flathead) are treated as one, even though they were historically separate. Montana's Indian Nations include:

- Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation
- Blackfeet Tribe of the Blackfeet Indian Reservation
- Confederated Salish & Kootenai Tribes of the Flathead Reservation
- Chippewa-Cree Indians of the Rocky Boy's Reservation
- Crow Tribe
- Fort Belknap Indian Community of the Fort Belknap Reservation of Montana (Assiniboine and Gros Ventre Tribes)
- Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation
- Little Shell Tribe of Chippewa Indians: a Band of the Chippewa Cree Tribe (seeking federal recognition)

In addition to the obstacles faced by all homeless people, Indian people may be facing additional barriers in their efforts to become housed. According to a HUD study (released November 2003), white renters were consistently favored over their American Indian counterparts in 28.6 percent of paired tests housing searches in the 3 metropolitan areas of Montana — Billings, Great Falls and Missoula. Discrimination was most observable on measures of availability: white testers were more often told that an advertised or other unit was available than were similarly qualified Native American testers inquiring about the same advertised unit. (HUD: *Discrimination in Metropolitan Housing Markets, Phase III*: www.huduser.org/Publications/pdf/

LOSS OF SYSTEM SUPPORT
...aging out, discharged and released

Loss of residential system support is a major risk factor for homelessness unless adequate transition services are in place. This is equally true of corrections, mental health services, chemical dependency treatment, foster care and other residential youth services. The following list is far from exhaustive, but is intended to provide representative examples of residential services provided in Montana.

Aging Out: Children come into the Department of Public Health and Human Services (DPHHS) foster care system because they were subjected to abuse and/or neglect, the long-term effects of which are manifested in a variety of complex ways. As of January 2004, approximately 1,900 children were in foster care under DPHHS, more than 600 of whom were between the ages of 13-19. Almost 170 were between the ages of 17-19. The majority of this last group is likely to leave foster care within the next two years. *(Note: These numbers do not include the children in the tribal or Bureau of Indian Affairs foster care systems.)*
Youth "aging out" of foster care are at increased risk of homelessness, unemployment, drug and alcohol use, non-marital pregnancies and involvement with the legal system. Many have no one to turn to for social, emotional or financial support after leaving foster care.

> ***We serve girls between the ages of 12—18. If discharged right at 18, many are not ready to become independent — they need supportive services during transition.***
> *— Executive director of a youth residential facility*

Adjudicated youth remanded to the state become residents of one of two juvenile correctional facilities, which serve youth up until age 18.

- Pine Hills, a youth correctional facility for males aged 10 — 17 provides 144 beds; and
- Riverside correctional facility for girls provides an additional 20 beds.

Discharged or Released: The Montana Department of Corrections reported an average daily caseload for probation and parole of 6,104 for FY 2002. These numbers have shown consistent growth for the past several years.

One private and 3 regional prisons provide additional housing for inmates. The regional prisons are in Cascade, Dawson and Missoula counties; Shelby is home to Montana's only private prison. It serves 400 males and 80 female prisoners at any given time. (Department of Corrections)

Prerelease centers are community-based correctional facilities operated under contract with the Department of Corrections. They provide supervision, counseling, assistance in locating employment, life skills training and guidance for adult male and female offenders.

Prerelease offers an alternative to direct release to the community and reintegrates people in a gradual, controlled manner. The Department of Corrections contracts with 5 non-profit prerelease centers that provide beds for 410 men and 110 women. There is also a contract for an additional 64 beds for chemical dependency treatment and services related to entering and exiting "boot camp."

Substance Abuse and Mental Health Treatment

- Montana Chemical Dependency Center treats 800 — 1,000 people annually; the average stay is 36 days.
- Montana State Hospital had an average daily census in FY 2003 of 178, with nearly 500 people experiencing mental illness treated and released.

Though efforts are made at individual program levels, there are no consistent statewide policies that emphasize the importance of preventing homelessness as a goal of discharge planning.

Issues

People who experience chronic homelessness face numerous obstacles to accessing services and housing. Some barriers to mainstream programs are obvious: when an individual is struggling with a disability or multiple disabilities, is living under the threat of domestic violence, lacks reliable transportation or child care, then fulfilling a variety of eligibility requirements in a number of different physical venues can be overwhelming. Limited literacy can make it difficult to complete forms; limited education and/or job skills can make it virtually impossible to access jobs that pay more than minimum wage. Finally, accessing commodities or making effective use of food stamps is problematic without a place to store or prepare food.

- **Access to mainstream services:** While virtually all families surveyed may have been eligible for mainstream assistance in the form of food stamps or Temporary Assistance for Needy Families (TANF), just 23.3% had accessed TANF; 21.7% had accessed food stamps.
- **Poverty** is widespread in Montana, with the majority of employment paying less than the living wage required to access housing at the Fair Market Rent. Most new jobs are in low-paying sectors.
- **Lack of low income housing:** Long waiting lists, limited assistance vouchers and few eligible properties mean years-long waiting lists.
- **Substance abuse, mental illness and co-occurring disorders** are prevalent, but for many, inpatient treatment options are limited to Montana Chemical Dependency Center — which usually has a waiting list — and Montana State Hospital, which routinely exceeds capacity.
- **Need for medical care:** Because preventive or early-stage medical care is often unavailable to the homeless, routine ailments frequently escalate to emergency status. A cavity, for example, can abscess and generate a life-threatening infection.
  - Nearly half of the 2003 Survey respondents stated that they needed medical care.
- **Lack of consistent policies can** mean that discharge planning is incomplete or inadequate. Loss of system support — whether it is mental health or chemical dependency treatment, foster care or corrections — can put people at high risk for homelessness.

  Responses to the *2003 Survey of the Homeless* provided some indication that loss of system support was a precursor to homelessness:
  - 8.2% of individuals and 3.5% of family spokesmen cited release from confinement as a contributor to their homelessness;
  - .9% of individuals and .6% of families cited aging out of foster care.
  - When asked where they spent the previous night, .6% of families and individuals said a detoxification facility; 5.4% of individuals and .6% of families said jail, prison or prerelease; 1.1% of individuals and .2% of families said a hospital.
- **Connection to the community:** The majority of the homeless surveyed had connections to the community — particularly of longevity. This speaks to the need for community-based solutions.
- **Education**: About 1/3 did not have the equivalent of a high school education and 39.9% of individuals and 42.1% of families stated that they needed job training, skills or counseling.
- Homelessness does not appear to be disproportionately high among **Montana veterans**, and is lower than national levels. Even so, by virtue of highly transient lifestyles, homeless veterans find it difficult to access benefits due to lengthy claim processes. Without adequate alternatives, this enhances the risk for homelessness.
- **Native Americans** and other minorities were overrepresented among the homeless surveyed. Native American people in Montana also experience poverty at much higher rates than their mainstream counterparts.
- **Gender-based wage inequality** is extreme, putting women without partners at high risk of homelessness as the direct result of poverty-related issues.
- **Multi-faceted needs** require multi-systemic solutions, but systems tend to be fragmented and funding geared to isolated rather than global issues.

Issues, *continued*

- **Domestic abuse:** The prevalence of domestic violence continues to escalate in Montana, cutting across age, racial, cultural and socioeconomic lines. Drug and/or alcohol abuse is frequently linked to domestic violence, and the repercussions for children include emotional, learning and behavioral problems, as well as an increased likelihood of repeating the pattern in their own lives.

  According to the Worcester Family Research Project, 92% of the homeless and 82% of housed low-income mothers included in their *National Center on Family Homelessness* Study had experienced severe physical and/or sexual assault.

A foundation to build from: Despite the issues, a lot is going right.

- Montana's **Continuum of Care (CoC)** efforts are one of the primary tools in the fight against chronic homelessness. Their primary mission is addressing homelessness statewide through collaboration, and by marshalling resources and building an effective referral network. The coalition is comprised of approximately 50 people coming from every planning district in the state, state associations and agencies, and the current and formerly homeless. The CoC provides an annual inventory of services for the homeless.

A Foundation to Build From

Many other efforts are also in play throughout Montana that support serving the homeless and those at risk of becoming homeless. A few of these include:

- **HRDCs:** Montana's 10 Human Resource Development Councils provide services geared to mitigating the effects of poverty. They sponsor a wide range of programs including commodity distribution, Meals on Wheels, Head Start, Low Income Energy Assistance, Weatherization and others.
- **Recovery & Mothers' and Children's Homes:** The Addictive and Mental Disorders Division sponsors 2 recovery homes for adults with substance abuse and other issues putting them at risk of homelessness. Three mothers' and children's homes provide wrap-around live-in services for mothers recovering from addictions and their children.
- **Community mental health centers and substance abuse services** are available statewide at the community level.
- There are 31 **domestic violence** programs statewide, many partially funded through the Montana Board of Crime Control, which disburses federal Violence Against Women Act (VAWA) and Victims Of Crime Act (VOCA) funds.
- The **Prevention Resource Center** provides resources to programs working in support of mitigating the effects of poverty through its VISTA (Volunteers In Service To America) project.
- **Projects for Assistance in Transition from Homelessness (PATH):** The federal PATH Program distributes grants for use by the four regional community mental health centers in their efforts to address the needs of people who are homeless and mentally ill.
- **Program of Assertive Community Treatment (PACT):** PACT is a community-based program for adults with such severe mental illness that they would not be able to function without services. Two are in operation, each serving 65—70 people with histories of lengthy or multiple stays in the State Hospital.
- There are **homeless shelters and food banks** in every major city as well as in many smaller areas. These are supported, in part, by **Community Services Block Grant** funds administered by the Intergovernmental Human Services Bureau.
- **Veterans Administration** outreach efforts and annual Stand Downs for homeless veterans.
- **HOME, CDBG** and **Low Income Housing Tax Credit** funds are available through the Department of Commerce, and are used in support of providing housing for income-eligible individuals and families. **Housing Authorities** also provide housing statewide for income-qualified individuals and families.
- The **Montana Foster Care Independence Program** of the Child and Family Services Division assists eligible youth in transition from foster care to independent living by providing funding for housing, utilities, household set-up and medical expenses. Assistance is available statewide. Assistance with post-secondary education, including board and room, is a separate but related component of the program.

Next Steps

POLICY ACADEMY *PRIORITIES*

In 2003, the U.S. departments of Health and Human Services and Housing & Urban Development held the 4th in a series of 2-day Policy Academies designed to help state and local policymakers improve access to mainstream services for people who are homeless. Eleven Montana stakeholders were chosen to attend. This group established the following priorities and created a work plan that will be used as a starting point for the Montana Interagency Council on Homelessness.

PRIORITY ONE: Coordinated Services — Establish leadership and create an effective structure to improve the coordination of homeless services statewide.

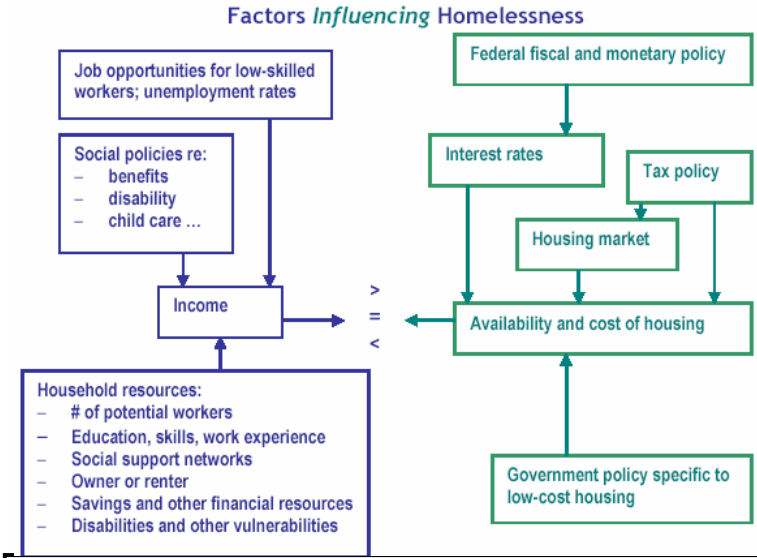
PRIORITY TWO: Case Management — Ensure effective case management with the homeless by improving and strengthening case management practices.

PRIORITY THREE: Mobilize Resources — Access all available resources and identify where new resources can make a critical difference.

PRIORITY FOUR: Outreach — Create new and leverage current outreach efforts in order to increase enrollment of hard-to-reach chronic homeless individuals.

Next Steps...or *How do we get there from here?* The top priority set by the Policy Academy on Homelessness is *coordinated services.* The first steps will be to determine how to best accomplish that — to determine exactly what is in place, and what is missing. Recommendations follow.

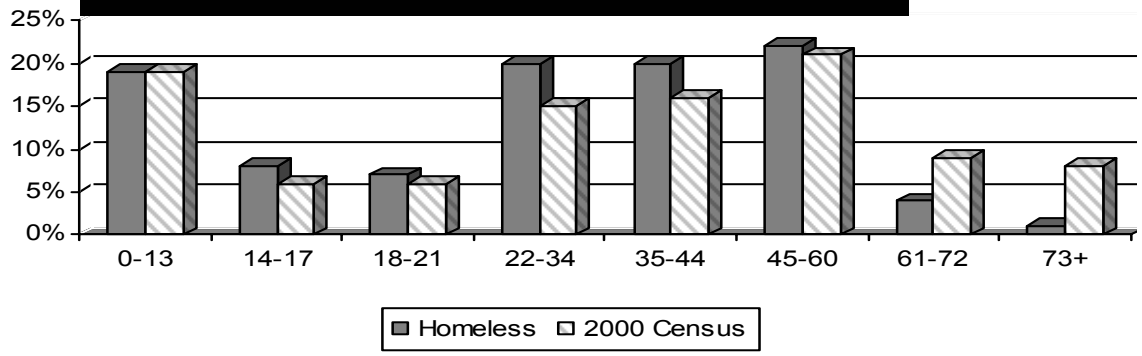
- Form an active **Council on Homelessness.**
- Create a **10-Year Plan** designed to end chronic homelessness within ten years.
- Look at ways to affect the **root causes** of homelessness through policy. These might include poverty, treatment availability for substance abuse/mental illness, domestic abuse and inadequate discharge policies resulting in the abrupt loss of system support.
- **Partner** with Montana's Tribal Nations to develop understanding of homelessness on the reservations and to find culturally competent solutions to homelessness.
- Since many of the issues leading to homelessness have their roots in childhood abuse, neglect and mobility, **prevention** will be one key to ending chronic homelessness.
- **Inventory** state program discharge policies and practices and help initiate best practice models.
- Enhance **collaboration** to increase access among the chronically homeless to mainstream resources. This will be accomplished through improved case management, resulting in increased numbers of referrals and enrollments.
- Examine mechanisms for establishing **presumptive eligibility** for Supplemental Security Income for persons who meet program income and disability criteria and who are at high risk of homelessness. Include those being discharged from state institutions and programs.



This diagram is adapted from one first published by Martha Burt in her book, *Over the Edge: The Growth of Homelessness in the 1980s.*

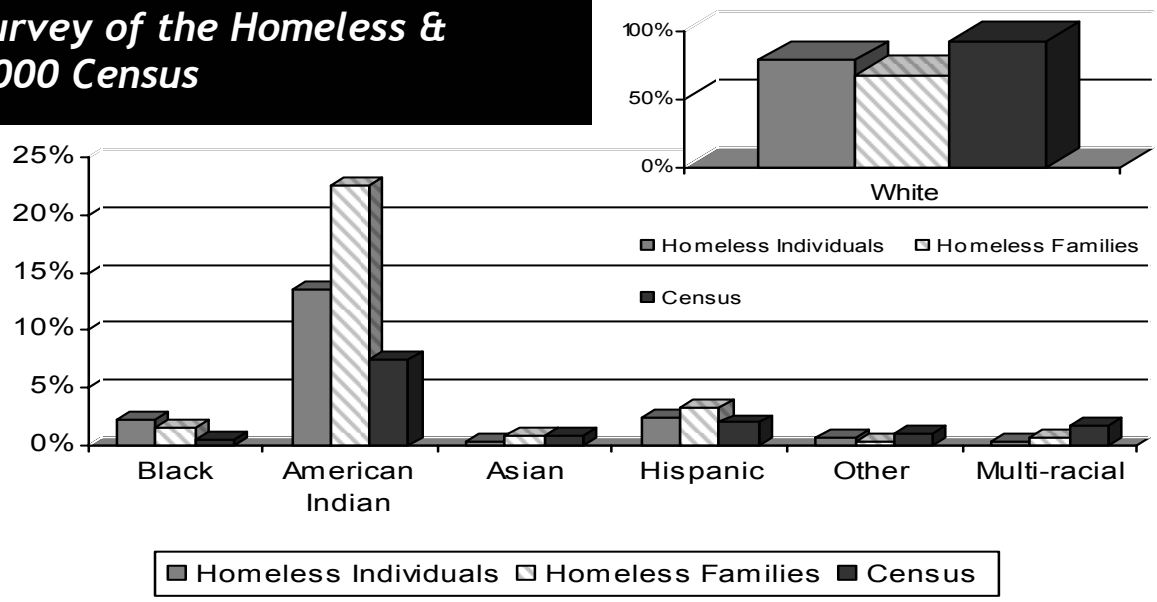
By the Numbers

Age Breakdown: *Survey of the Homeless and 2000 Census*



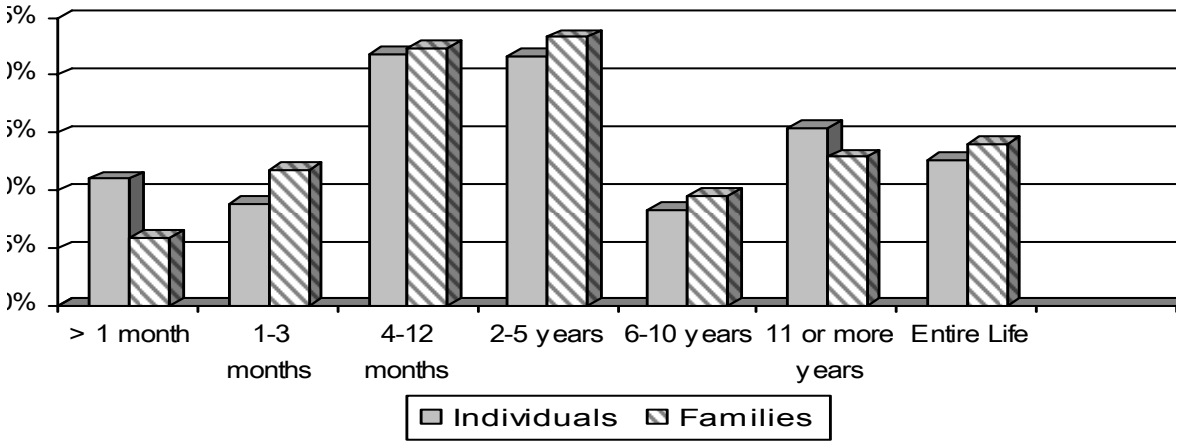
Age: Sixty-two (62) percent of the homeless individuals and families represented in the survey fell between the ages of 22 — 60; 19 percent were between the ages of 0—13 on both the survey and the 2000 Census.

Racial/Ethnic Breakdown: *Survey of the Homeless & 2000 Census*

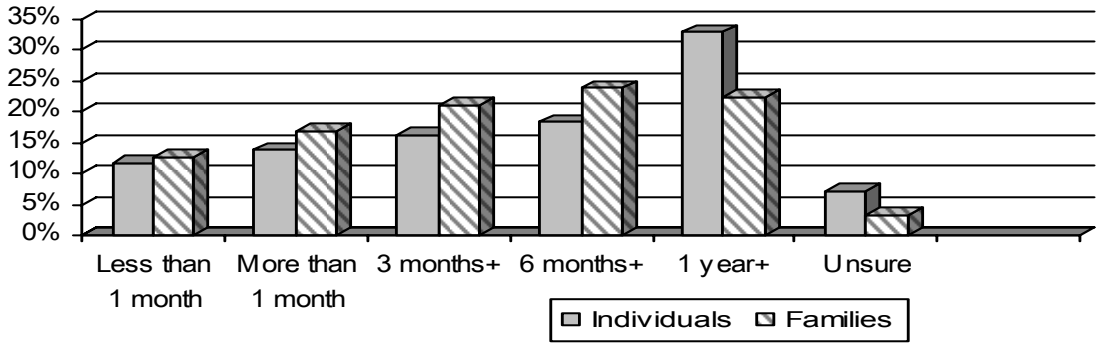


Disproportionate Minority Representation: Although the majority of the homeless surveyed were White (78.5 percent of individuals and 67.7 percent of families), the majority is significantly lower than might be expected given 2000 Census data, which indicates that 92.2 percent of the population of Montana as a whole is White. There is significant disproportionate representation among *all* racial/ethnic groups, but it is particularly evident among American Indians, as demonstrated by the comparative charts above.

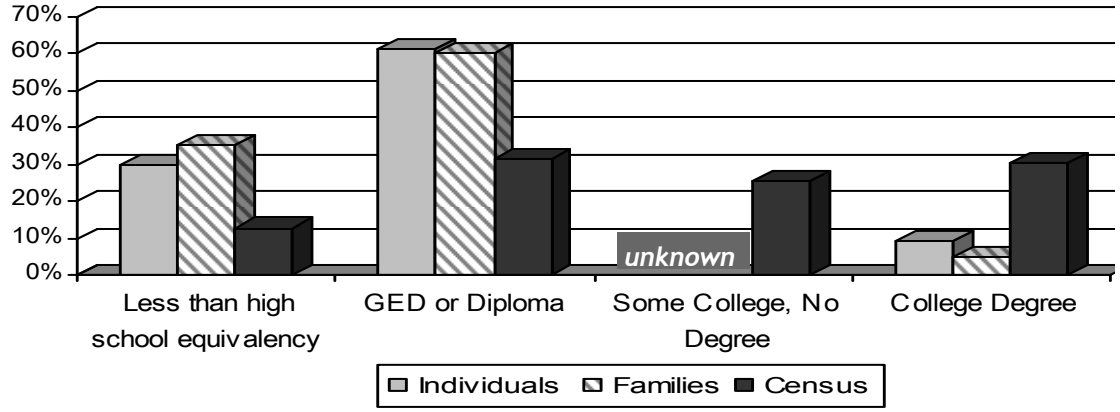
How long have you lived in the community or area?



How long have you been without permanent & safe housing?



What level of education do you have?



Most of the homeless individuals and families surveyed had lived in the community for more than two years, been without housing for at least six months, and had a high school education or *less*.

Sources and Resources

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4. Homelessness: Improving Program Coordination and Client Access to Programs. U.S. General Accounting Office. http://www.gao.gov/new.items/d02485t.pdf
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9. Youth Homelessness: case studies of the reconnect program. http://www.facs.gov.au/internet/facsinternet.nsf/vIA/youth_homelessness/$file/YouthHomelessness.pdf

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4. Putting Montana's Population Changes into Perspective: the *Missoulian* on Census 2000. http://www.missoulian.com/specials/population/
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4. *The Many Faces of Poverty*. Rocky Mountain Development Council, Inc. Helena, Montana. 2001

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2. Montana: Websites for Detailed County Health Profile and Other Data http://www.dphhs.state.mt.us/hpsd/pubheal/healplan/profiles/websites.pdf

Homelessness

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2. Estimating Homelessness: Toward A Methodology for Counting The Homeless in Canada. http://www.cmhc-schl.gc.ca/en/imquaf/ho/ho_005.cfm
3. Homeless Policy Academies. Health. http://www.hrsa.gov/homeless/index.htm
4. HUD: Figures and Tables on the Homeless. http://www.huduser.org/publications/homeless/homelessness/figs_tbls.html
5. Interagency Council on Homelessness. http://www.ich.gov/
6. Knowledgeplex: the Professional Resource for Affordable Housing and Community Development. http://www.knowledgeplex.org/
7. Missoula Homeless Facilities and Services. http://www.co.missoula.mt.us/measures/arhc.htm
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10. Rural Homelessness: National Coalition for the Homeless Fact Sheet. 1999. http://www.nationalhomeless.org/rural.html
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3. Montana's Legislative Bills: http://laws.leg.state.mt.us/pls/laws03/law0203w$.startup

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2. *Prevention Connection* Newsletter. http://state.mt.us/prevention/resources/prevconn/prevconn.htm
3. Prevention Resource Center. www.state.mt.us/prevention

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4. Dual Diagnosis Recover Network: articles and publications about co-occurring disorders. http://www.dualdiagnosis.org/library/library.html
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3. Montana Wyoming Tribal Leaders Council: http://tlc.wtp.net/index.html.htm
4. Tribal Resource Guide: www.ojp.usdoj.gov/americannative/tribalresourceguide.pdf

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1. Addressing Issues From Hunting to Homelessness: A Report to the 57th Legislature leg.state.mt.us/content/publications/committees /interim/1999_2000/state_ administration/ finalreport-vets.pdf#xm
2. National Coalition for Homeless Veterans. http://www.nchv.org/

Montana — the last, best frontier

The Last Frontier: Montana is the 4th largest state in the nation, with most of its 902,195 inhabitants clustered around seven urban centers. The remaining population is so scattered that 45 of Montana's 56 counties have frontier status, or fewer than six people/square mile. Even the Billings Metropolitan Statistical Area (MSA) — Montana's largest city — is relatively small, with just 129,352 residents. (2000 Census)

Disclaimer: *Annual Survey of the Homeless*

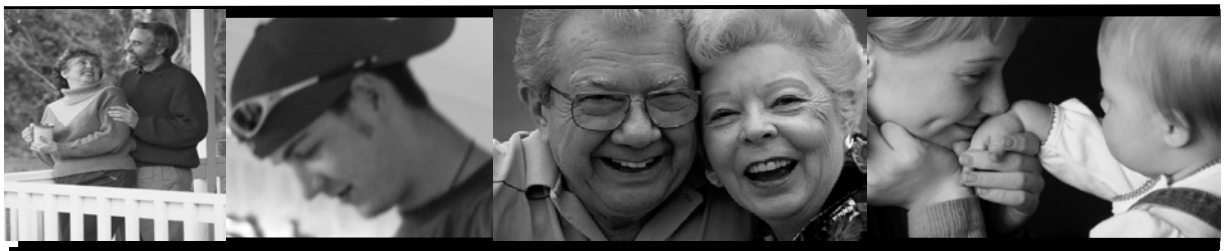
Through the *Annual Survey of the Homeless*, the attempt is made to reach as many homeless individuals and homeless families as possible. This is done largely through volunteer efforts. This data describes only those who were reached during the point-in-time survey taken in the seven urban centers of Montana over the course of three days in April 2003. It is impossible to conduct an exhaustive count, but the attempt is made to provide a reasonable indication of the extent of the problem and to profile who the homeless in Montana are.

Although this survey cannot be considered a census of the homeless in Montana, the profile does shed light on where it might be possible to effect change in homelessness through policy.

- Survey approaches are a legitimate, valuable tool for understanding the prevalence of a condition such as chronic homelessness, and for understanding the characteristics of those experiencing that condition.

For more information, contact Jim Nolan, Bureau Chief
Intergovernmental Human Services Bureau — Human and Community Services Division — 1400 Carter Drive — Helena, Montana 59620 Telephone: 406-447-4260 — Fax: 406-447-4287 — Email: jnolan@state.mt.us (Note: Copies of the 2003 survey and complete results are available upon request or on the DPHHS website.)

MONTANA
Department of Public Health & Human Services



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